

FIG. 1

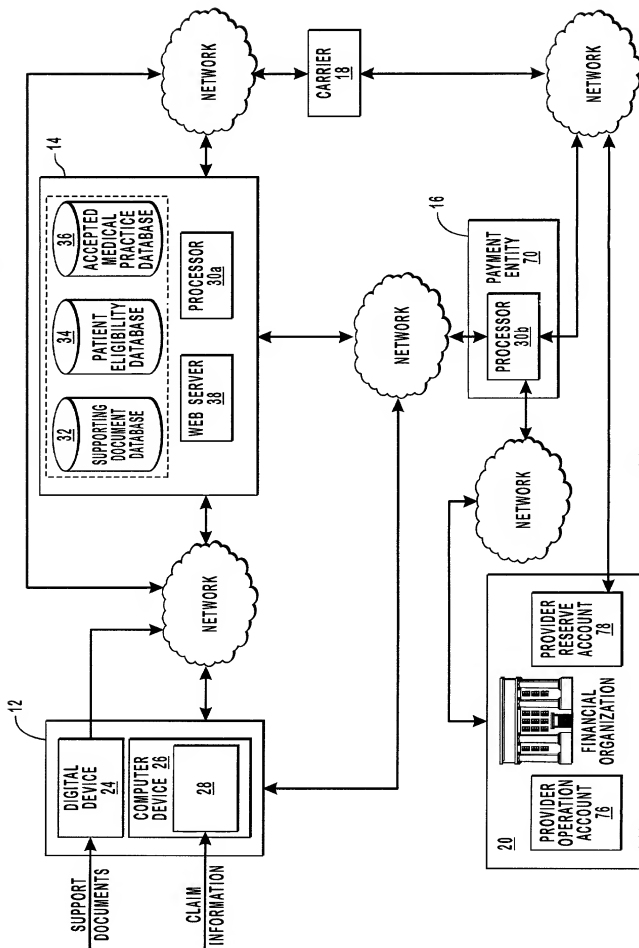


FIG. 2

28a

Health Care Claims Form

Plan ID	
Insured's ID	
Patient's date of birth	- mm/dd/yy
Provider ID	

40 42 44 46

FIG. 3

28b

Health Care Claims Form

50 { Plan ID : 1234
Insured : Doe, John 541XXXXX
Patient : 01, Jane
Provider: MISCELLANEOUS PROVIDERS

Please enter the Patient Dependent Number from above from above: 56

Last Name, First, Middle Initial, I.D.

Referring Physician

Service Provider

Diagnosis or Nature of Illness or Injury.

52 52

Dates of Service		Place	Type	Procedure, Service or Supplies		Diagnosis No		SCharges
From	To	Svc	Svc	CPT	Modifier			
				54				60

Patient's Account	Accept Assign?	Total Charge	62
	Yes <input type="radio"/> No <input type="radio"/>	Amount Paid	58
		Balance Due	64

FIG. 4

